FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031823

Facility Name: WINDMILL NURSING PAVILION

Address: 16000 S. WABASH (Number) SOUTH HOLLAND (City) 60473 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-3485403

Date of Initial License for Current Owners: 01/02/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Previe

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 1

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,600	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,300	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,414	(108)	1,703	4,009	8
9	SNF/PED					9
10	ICF	43,562	1,980	787	46,329	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,976	1,872	2,490	50,338	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 91.69%

D. How many bed-hold days during this year were paid by Public Aid 1,185 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 01/02/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/2/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 13 and days of care provided _____

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual bas

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12/31/2000
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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	169,913	17,411	6,369	193,693		193,693	0	193,693			1
2	Food Purchase		187,818		187,818	(27,413)	160,405	(1,254)	159,151			2
3	Housekeeping	17,789	17,980	0	35,769		35,769	0	35,769			3
4	Laundry	0	14,322	74,884	89,206		89,206	0	89,206			4
5	Heat and Other Utilities			94,801	94,801		94,801	715	95,516			5
6	Maintenance	54,414	28,215	143,688	226,317		226,317	23,602	249,919			6
7	Other (specify):*			9,860	9,860		9,860	597	10,457			7
8	TOTAL General Services	242,116	265,746	329,602	837,464	(27,413)	810,051	23,660	833,711			8
	B. Health Care and Programs											
9	Medical Director			600	600		600	0	600			9
10	Nursing and Medical Records	1,605,196	46,904	70,404	1,722,504		1,722,504	(1,884)	1,720,620			10
10a	Therapy	0	573	16,800	17,373		17,373	0	17,373			10a
11	Activities	100,799	9,200	2,759	112,758		112,758	0	112,758			11
12	Social Services	25,220		4,212	29,432		29,432	0	29,432			12
13	Nurse Aide Training			0				110	110			13
14	Program Transportation			0				0				14
15	Other (specify):* DRUGS		6,224		6,224		6,224	0	6,224			15
16	TOTAL Health Care and Progra	1,731,215	62,901	94,775	1,888,891		1,888,891	(1,774)	1,887,117			16
	C. General Administration											
17	Administrative	98,401		120,000	218,401		218,401	57,811	276,212			17
18	Directors Fees			0				0				18
19	Professional Services			30,766	30,766		30,766	7,222	37,988			19
20	Dues, Fees, Subscriptions & Promotions			64,912	64,912		64,912	(37,906)	27,006			20
21	Clerical & General Office Expense	99,232	14,982	206,702	320,916		320,916	(136,078)	184,838			21
22	Employee Benefits & Payroll Taxes			366,427	366,427	27,413	393,840	0	393,840			22
23	Inservice Training & Education			0				0				23
24	Travel and Seminar			4,085	4,085		4,085	579	4,664			24
25	Other Admin. Staff Transportation			1,545	1,545		1,545	26	1,571			25
26	Insurance-Prop.Liab.Malpractice			84,823	84,823		84,823	677	85,500			26
27	Other (specify):*			0				16,497	16,497			27
28	TOTAL General Administration	197,633	14,982	879,260	1,091,875	27,413	1,119,288	(91,172)	1,028,116			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,170,964	343,629	1,303,637	3,818,230		3,818,230	(69,286)	3,748,944			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			71,787	71,787		71,787	86,529	158,316			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			198	198		198	324,823	325,021			32
33	Real Estate Taxes			239,206	239,206		239,206	1,682	240,888			33
34	Rent-Facility & Grounds			585,997	585,997		585,997	(585,997)				34
35	Rent-Equipment & Vehicles			4,620	4,620		4,620	6,999	11,619			35
36	Other (specify):*							0				36
37	TOTAL Ownership			901,808	901,808		901,808	(165,964)	735,844			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		36,935	46,851	83,786		83,786	(1,967)	81,819			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			82,350	82,350		82,350	0	82,350			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		36,935	129,201	166,136		166,136	(1,967)	164,169			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,170,964	380,564	2,334,646	4,886,174	0	4,886,174	(237,217)	4,648,957			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 **Report Period Beginning:** 01/01/2000 **Ending:**

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(108,366)	30		9
10	Interest and Other Investment Income	(198)	32		10
11	Discounts, Allowances, Rebates & Refunds	(760)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(494)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties		21		18
19	Entertainment	0	20		19
20	Contributions	(3,325)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(35,385)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	16,075	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (132,453)		$	30

OHF USE ONLY									
48		49		50		51		52	

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B. If there are expenses experienced by the facility which do n general ledger, they should be entered below.(See instructio

		1 Amount
31	Non-Paid Workers-Attach Schedule*	$
32	Donated Goods-Attach Schedule*	
33	Amortization of Organization & Pre-Operating Expense	
34	Adjustments for Related Organization Costs (Schedule VII)	(104,764)
35	Other- Attach Schedule	0
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (104,764)
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (237,217)

***These costs are only allowable if they are necessary to meet licensing standards. Attach a schedule detailing the items ir on these lines.**

C. Are the following expenses included in Sections A to D of p and 4? If so, they should be reclassified into Section E. Plea reference the line on which they appear before reclassificati (See instructions.)

		1 Yes	2 No	3 Amount
38	Medically Necessary Transport.		X	$
39				
40	Gift and Coffee Shops		X	
41	Barber and Beauty Shops		X	
42	Laboratory and Radiology		X	
43	Prescription Drugs		X	
44	Exceptional Care Program		X	
45	Other-Attach Schedule			
46	Other-Attach Schedule			
47	**TOTAL (C): (sum of lines 38-46)**			$

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Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name **WINDMILL NURSING PAVILION**

ID# **0031823**

Report Period Beginning: **01/01/2000**

Ending: **12/31/2000**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(1,254)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	16,075
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7**	0
8	**Laundry for Non-Patients**	0	4	**Line 8**	14,821
9	**Non-Straightline Depreciation**	(108,366)	30	**Line 9**	0
10	**Interest and Other Investment Income**	(198)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	(760)	2	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(494)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15**	0
17	**Non-Care Related Fees**	0	20	**Line 16**	0
18	**Fines and Penalties**	0	21	**Line 17**	0
19	**Entertainment**	0	20	**Line 18**	0
20	**Contributions**	(3,325)	20	**Line 19**	0
21	**Owner or Key-Man Insurance**	0	22	**Line 20**	(38,710)
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 21**	0
23	**Malpractice Insurance for Individuals**	0	26	**Line 22**	0
24	**Bad Debt**	0	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(35,385)	20	**Line 24**	0
26	**Income & IL Personal Property ReplacementTa**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26**	0
28	**Yellow Page Advertising**	0	20	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(38,710)
30	**Donated Goods**	0	0	**Line 29**	(23,889)
31	**Amortization Expense**	0	0	**Line 30**	(108,366)
32	DEFERRED MAINTENANCE	16,075	6	**Line 31**	0
33				**Line 32**	(198)

Print Other Adjustment

Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	(108,564)
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(132,453)

124
125

Reference 1	Reference 2	Reference 3	Reference 4

Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20

Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38

Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb: WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,254)	0	0	0	0	0	0	0	0	0	0	(1,254)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	715	0	0	0	0	0	0	0	0	715	5
6	Maintenance	16,075	0	3,653	3,874	0	0	0	0	0	0	0	23,602	6
7	Other (specify):*	0	0	103	0	494	0	0	0	0	0	0	597	7
8	**TOTAL General Services**	14,821	0	4,471	3,874	494	0	0	0	0	0	0	23,660	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(1,884)	0	0	0	0	0	(1,884)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	110	0	0	0	0	0	0	0	0	110	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	110	0	0	(1,884)	0	0	0	0	0	(1,774)	16
	C. General Administration													
17	Administrative	0	(100,800)	0	158,611	0	0	0	0	0	0	0	57,811	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,496	1,726	0	0	0	0	0	0	0	0	7,222	19
20	Fees, Subscriptions & Promotions	(38,710)	0	723	0	0	81	0	0	0	0	0	(37,906)	20
21	Clerical & General Office Expenses	0	(182,900)	43,195	3,627	0	0	0	0	0	0	0	(136,078)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	579	0	0	0	0	0	0	0	0	579	24
25	Other Admin. Staff Transportation	0	0	26	0	0	0	0	0	0	0	0	26	25
26	Insurance-Prop.Liab.Malpractice	0	0	677	0	0	0	0	0	0	0	0	677	26
27	Other (specify):*	0	0	5,726	0	10,771	0	0	0	0	0	0	16,497	27
28	**TOTAL General Administration**	(38,710)	(278,204)	52,652	162,238	10,771	81	0	0	0	0	0	(91,172)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,889)	(278,204)	57,233	166,112	11,265	(1,803)	0	0	0	0	0	(69,286)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS **Summary B**

Facility Name & ID Numb **WINDMILL NURSING PAVILION** **#** **0031823** **Report Period Beginning:** **01/01/2000 Ending:** **12/31/2000**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(108,366)	191,904	2,991	0	0	0	0	0	0	0	0	86,529	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(198)	322,860	2,161	0	0	0	0	0	0	0	0	324,823	32
33	Real Estate Taxes	0	0	1,682	0	0	0	0	0	0	0	0	1,682	33
34	Rent-Facility & Grounds	0	(585,997)	0	0	0	0	0	0	0	0	0	(585,997)	34
35	Rent-Equipment & Vehicles	0	0	6,999	0	0	0	0	0	0	0	0	6,999	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(108,564)	(71,233)	13,833	0	0	0	0	0	0	0	0	(165,964)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(1,967)	0	0	0	0	0	(1,967)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	(1,967)	0	0	0	0	0	(1,967)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(132,453)	(349,437)	71,066	166,112	11,265	(3,770)	0	0	0	0	0	(237,217)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning 01/01/2000 Ending: 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necess

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Bus
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organizat Costs (7 minus 4)
1	V	17	MANAGEMENT FEE	$ 100,800	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (100,800)
2	V	21	BOOKKEEPING SVC	182,900	" " "			(182,900)
3	V							
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V	34	RENT	585,997	16000 S. WABASH PARTNERSHIP			(585,997)
11	V	19	ACCOUNTING & LEGAL		" " "		5,496	5,496
12	V	30	DEPRECIATION		" " "		191,904	191,904
13	V	32	INTEREST		" " "		322,860	322,860
14	Total			$ 869,697			$ 520,260	$ * (349,437)

* Total must agree with the amount recorded on line 34 of Schedule VI.

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

sary	
siness	

tion	Sum_6
1	-100800
2	-182900
3	
4	
5	
6	
7	
8	
9	
10	-585997
11	5496
12	191904
13	322860
14	

Line 1	Line 2	Line 3	Line 4	Line 5	Line 6	Line 7	Line 9	Line 10	Line 10a	Line 11	Line 12	Line 13	Line 14	Line 15

Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33

Line	Line	Line	Line	Line	Line	Line	Line	Line
34	35	36	38	39	40	41	42	43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginnir 01/01/2000 Ending:

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Di
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjust Related Costs (
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 715	$
16	V	6	REPAIRS & MAINT.		" " "	100.00%	3,653	
17	V	7	EMP. BEN. - GEN. SERVICES		" " "	100.00%	103	
18	V	13	NURSES AIDE TRAINING		" " "	100.00%	110	
19	V	19	PROFESSIONAL FEES		" " "	100.00%	1,726	
20	V	20	DUES AND SUBSCRIPTION		" " "	100.00%	723	
21	V	21	CLERICAL & GENERAL		" " "	100.00%	43,195	
22	V	24	SEMINARS AND TRAVEL		" " "	100.00%	579	
23	V	25	ADMIN. STAFF TRANS		" " "	100.00%	26	
24	V	26	INSURANCE		" " "	100.00%	677	
25	V	27	EMP BEN. - GEN ADMIN.		" " "	100.00%	5,726	
26	V	30	DEPRECIATION		" " "	100.00%	2,991	
27	V	32	INTEREST		" " "	100.00%	2,161	
28	V	33	REAL ESTATE TAXES		" " "	100.00%	1,682	
29	V	35	EQUIPMENT RENTAL		" " "	100.00%	6,999	
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total			$			$ 71,066	$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

ifference: tments for d Organization 7 minus 4)		Sum_6A
715	**15**	715
3,653	**16**	3653
103	**17**	103
110	**18**	110
1,726	**19**	1726
723	**20**	723
43,195	**21**	43195
579	**22**	579
26	**23**	26
677	**24**	677
5,726	**25**	5726
2,991	**26**	2991
2,161	**27**	2161
1,682	**28**	1682
6,999	**29**	6999
	30	
	31	
	32	
	33	
	34	
	35	
	36	
	37	
	38	
71,066	**39**	

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginnir 01/01/2000 Ending:

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Di
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjust Relatec Costs (
15	V		6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 3,874	$
16	V		10	NURSING CMP - SUE G.		" " "	100.00%		
17	V		17	ADMIN. CMP. - M. MAUER		" " "	100.00%	31,272	
18	V		17	ADMIN. CMP. - M. AARON		" " "	100.00%	40,072	
19	V		17	ADMIN. CMP. - F. AARON		" " "	100.00%	28,807	
20	V		17	ADMIN. CMP. - A. STERN		" " "	100.00%	25,265	
21	V		17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%		
22	V		17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%		
23	V		17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%	8,284	
24	V		17	ADMIN. CMP. - E. CASSON		" " "	100.00%		
25	V		17	ADMIN. CMP. - S. BOGEN		" " "	100.00%		
26	V		17	ADMIN. CMP. - S. LEVY		" " "	100.00%	9,122	
27	V		17	ADMIN. CMP. - A. STEINER		" " "	100.00%	2,989	
28	V		17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	12,800	
29	V		21	CLERICAL CMP. - S. AARON		" " "	100.00%	3,627	
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total				$			$ 166,112	$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

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5. The adjustments entered on this page will automatically transfer to the summary pages.

ifference: tments for d Organization 7 minus 4)		Sum_6B
3,874	**15**	3874
	16	
31,272	**17**	31272
40,072	**18**	40072
28,807	**19**	28807
25,265	**20**	25265
	21	
	22	
8,284	**23**	8284
	24	
	25	
9,122	**26**	9122
2,989	**27**	2989
12,800	**28**	12800
3,627	**29**	3627
	30	
	31	
	32	
	33	
	34	
	35	
	36	
	37	
	38	
166,112	**39**	

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginnir 01/01/2000 Ending:

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Di
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjust Related Costs (
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 494	$
16	V	15	EMP. BEN. - SUE G.		" " "	100.00%		
17	V	27	EMP. BEN. - M. MAUER		" " "	100.00%	874	
18	V	27	EMP. BEN. - M. AARON		" " "	100.00%	1,016	
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%	3,554	
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%		
21	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%		
22	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%	1,363	
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%		
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%		
25	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	1,250	
26	V	27	EMP. BEN. - A. STEINER		" " "	100.00%	496	
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%	1,722	
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	496	
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total			$			$ 11,265	$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

ifference: tments for d Organization 7 minus 4)		Sum_6C
494	**15**	494
	16	
874	**17**	874
1,016	**18**	1016
3,554	**19**	3554
	20	
	21	
1,363	**22**	1363
	23	
	24	
1,250	**25**	1250
496	**26**	496
1,722	**27**	1722
496	**28**	496
	29	
	30	
	31	
	32	
	33	
	34	
	35	
	36	
	37	
	38	
11,265	**39**	

Print Page 6

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STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION **#** 0031823 **Report Period Beginnir** 01/01/2000 **Ending:**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] **YES** [ ] **NO**

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Di
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjust Related Costs (
15	V		10a	THERAPY	$ 16,800	DYNAMIC REHAB CONSULTANTS LLC		$ 16,800	$
16	V		22	EMPLOYEE BENEFITS		" " "			
17	V		39	ANCILLARY SERVICES	41,756	" " "		41,756	
18	V								
19	V								
20	V		10	NURSING & MEDICAL SUPP	15,188	PHARMCOR LLC		15,188	
21	V		11	ACTIVITIES		" "			
22	V		22	EMPLOYEE BENEFITS	75	" "		75	
23	V		39	ANCILLARY EXPENSE	25,736	" "		25,736	
24	V								
25	V								
26	V		20	DUES, FEES & SUBSCRIPTION	(308)	LINCOLN MEDICAL SUPPLIES, INC.		(227)	
27	V		10	MEDICAL SUPPLIES	7,160	" " "		5,276	
28	V		39	ANCILLARY EXPENSE	7,476	" " "		5,509	
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total				$ 113,883			$ 110,113	$ *

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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5. The adjustments entered on this page will automatically transfer to the summary pages.

ifference: tments for d Organization 7 minus 4)		Sum_6D
	15	
	16	
	17	
	18	
	19	
	20	
	21	
	22	
	23	
	24	
	25	
81	**26**	81
(1,884)	**27**	-1884
(1,967)	**28**	-1967
	29	
	30	
	31	
	32	
	33	
	34	
	35	
	36	
	37	
	38	
(3,770)	**39**	

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	ABE STERN		ADMINISTRATIVE			SCHEDULE ATTACHI		CONSULTI	$ 25,265	17-7	1
2	MARSHALL MAUER		ADMINISTRATIVE					SALARY	31,272	17-7	2
3	MAURICE AARON		ADMINISTRATIVE					SALARY	40,072	17-7	3
4	FRED AARON		ADMINISTRATIVE					SALARY	28,807	17-7	4
5	" "							MGMT FEE	19,200	17-3	5
6	SHARON AARON		CLERICAL					SALARY	3,627	21-7	6
7											7
8			SCHEDULE								8
9			ATTACHED								9
10											10
11											11
12											12
13								TOTAL	$ 148,243		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Previe

the name(s)
PORTS.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679-8219
Fax Number: ((847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6
1	5	UTILITIES	TOTAL PATIENT DAYS	707,726	15	$ 10,055	$	50,338	$ 715
2	6	REPAIRS & MAINT	" "	707,726	15	51,362	16,071	50,338	3,653
3	7	EMP. BEN. - GEN. SVC.	" "	707,726	15	1,448		50,338	103
4	13	NURSES AIDE TRAINING	" "	707,726	15	1,550		50,338	110
5	19	PROFESSIONAL FEES	" "	707,726	15	24,272		50,338	1,726
6	20	DUES & SUBSCRIPTIONS	" "	707,726	15	10,163		50,338	723
7	21	CLERICAL & GENERAL	" "	707,726	15	607,305	465,093	50,338	43,195
8	24	SEMINARS & TRAVEL	" "	707,726	15	8,134		50,338	579
9	25	ADMIN. STAFF TRANS.	" "	707,726	15	372		50,338	26
10	26	INSURANCE	" "	707,726	15	9,517		50,338	677
11	27	EMP.BEN. - GEN. ADMIN.	" "	707,726	15	80,498		50,338	5,726
12	30	DEPRECIATION	" "	707,726	15	42,057		50,338	2,991
13	32	INTEREST	" "	707,726	15	30,386		50,338	2,161
14	33	REAL ESTATE TAXES	" "	707,726	15	23,654		50,338	1,682
15	35	EQUIPMENT RENTAL	" "	707,726	15	98,401		50,338	6,999
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	TOTALS					$ 999,174	$ 481,164		$ 71,066

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SULTANTS

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Print Page 8

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679-8219
Fax Number: ((847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	14	$ 54,000	$ 54,000	3	$ 3,874
2	10	NURSING - SUE G.	" "	40	1	32,209	32,209		0
3	17	ADMIN. CMP. - M. MAUER	" "	40	14	435,842	435,842	3	31,272
4	17	ADMIN. CMP. - M. AARON	" "	45	14	558,156	558,156	3	40,072
5	17	ADMIN. CMP. - F. AARON	" "	50	7	160,040	160,040	9	28,807
6	17	ADMIN. CMP. - A. STERN	" "	8	14	351,664		1	25,265
7	17	ADMIN. CMP. - S. GOLDSTI	" "	50	3	179,079	179,079		0
8	17	ADMIN. CMP. - S. KOPLIN	" "	45	10	67,732	67,732		0
9	17	ADMIN. CMP. - D. MAGAFA	" "	45	10	82,127	82,127	5	8,284
10	17	ADMIN. CMP. - E. CASSON	" "	45	2	47,882	47,882		0
11	17	ADMIN. CMP. - S. BOGEN	" "	45	3	119,320	119,320		0
12	17	ADMIN. CMP. - S. LEVY	" "	55	14	126,974	126,974	4	9,122
13	17	ADMIN. CMP. - A. STEINER	" "	45	14	41,511	41,511	3	2,989
14	17	ADMIN. CMP. - NON-OWNE	" "	45	14	178,292	178,292	3	12,800
15	21	CLERICAL CMP. - S. AARO	" "	40	14	50,548	50,548	3	3,627
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	TOTALS					$ 2,485,376	$ 2,133,712		$ 166,112

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Print Page 8

STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679-8219
Fax Number: ((847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6
1	7	EMP BEN - D. NEHMER	WGHTD. AVG. HOURS	40	14	$ 6,887	$	3	$ 494
2	15	EMP BEN - SUE G	" "	40	1	2,883			0
3	27	EMP BEN - M. MAUER	" "	40	14	12,175		3	874
4	27	EMP BEN - M. AARON	" "	45	14	14,155		3	1,016
5	27	EMP BEN - F. AARON	" "	50	7	19,744		9	3,554
6	27	EMP BEN - S. GOLDSTEIN	" "	50	3	18,514			0
7	27	EMP BEN - S. KOPLIN	" "	45	10	14,423			0
8	27	EMP BEN - D. MAGAFAS	" "	45	10	13,516		5	1,363
9	27	EMP BEN - E. CASSON	" "	45	2	10,284			0
10	27	EMP.BEN. - S. BOGEN	" "	45	3	7,029			0
11	27	EMP BEN - S. LEVY	" "	55	14	17,400		4	1,250
12	27	EMP BEN - A. STEINER	" "	45	14	6,891		3	496
13	27	EMP BEN - NON-OWNER	" "	45	14	23,984		3	1,722
14	27	EMP BEN - S. AARON	" "	40	14	6,917		3	496
15								3	
16									
17									
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21									
22									
23									
24									
25	TOTALS					$ 174,802	$		$ 11,265

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Print Page 8

STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679-8219
Fax Number: ((847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6
1		DYNAMIC REHAB CONSULTANTS				$	$		$
2	10a	THERAPY	DIRECT ALLOCATION						16,800
3	22	EMPLOYEE BENEFITS	" "						
4	39	ANCILLARY SERVICES	" "						41,756
5									
6									
7		PHARCOR LLC							
8	10	NURSING & MEDICAL SUP	DIRECT ALLOCATION						15,188
9	22	EMPLOYEE BENEFIT	" "						75
10	39	ANCILLARY EXPENSE	" "						25,736
11									
12									
13		LINCOLN MEDICAL SUPPLIES							
14	20	DUES, FEES & SUBSCRIPTI	DIRECT ALLOCATION						(227)
15	10	MEDICAL SUPPLIES	" "						5,276
16	39	ANCILLARY EXPENSE	" "						5,509
17									
18									
19									
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22									
23									
24									
25	TOTALS					$	$		$ 110,113

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Print Page 8

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6
1						$	$		$
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25	TOTALS					$	$		$

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Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MID NORTH BANK		X	MORTHGAGE	$42,054.00		$	$ 2,268,452		9.25	$ 212,735	1
2	AMERICAN NATIONAL BANK		X	MORTHGAGE	$55,899.00	10/00	5,625,000	5,595,554		8.65	110,125	2
3												3
4												4
5												5
	Working Capital											
6			X	WORKING CAPITAL						PRIME+	198	6
7												7
8	RELATED PARTY	X									2,161	8
9	TOTAL Facility Related				$97,953.00		$ 5,625,000	$ 7,864,006			$ 325,219	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,625,000	$ 7,864,006			$ 325,219	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe: WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	240,000
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	237,206
3. Under or (over) accrual (line 2 minus line 1).	$	(2,794)
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	242,000
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	239,206

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	215,205	8
	1996	224,885	9
	1997	224,837	10
	1998	232,380	11
	1999	237,206	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 1999	$
14	PLUS APPEAL COST FROM LINE 5	$
15	LESS REFUND FROM LINE 6	$
16	AMOUNT TO USE FOR RATE CALCULATIC	$

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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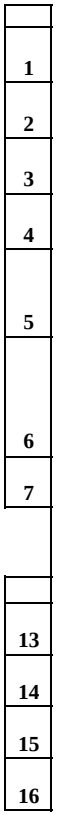
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STATE OF ILLINOIS

Facility Name & ID Numbe WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending:

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,054 B. General Construction Type: Exterior BRICK Frame Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Ur Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Co Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 354,221	1
2					2
3	TOTALS			$ 354,221	3

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Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1986	1976	$ 3,187,988	$ 191,904	30	$ 106,266	$ (85,638)	$ 1,487,724	4
5											5
6											6
7											7
8					31,552	808	35	901	93	6,611	8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	LEASEHOLD IMPROVEMENT			1989	6,334	201	31.5	201		2,303	9
10	LEASEHOLD IMPROVEMENT			1990	1,538	49	20	77	28	576	10
11	LEASEHOLD IMPROVEMENT			1991	26,695	848	20	1,335	487	9,517	11
12	LEASEHOLD IMPROVEMENT			1992	4,785	152	20	239	87	1,553	12
13	LEASEHOLD IMPROVEMENT			1993	8,024	255	31.5	255		1,980	13
14	LEASEHOLD IMPROVEMENT			1993	36,822	944	39	944		6,949	14
15	LEASEHOLD IMPROVEMENT			1994	38,826	996	39	996		6,169	15
16	LEASEHOLD IMPROVEMENT			1995	21,539	553	39	553		3,131	16
17	FLOOR MOUNTED TANK, WALL MOUNTED SINK, CONDI			1996	1,604	41	39	41		197	17
18	ROOF REPAIR			1996	3,800	97	39	97		433	18
19	GAZEBO			1996	1,282	33	39	33		144	19
20	ASPHALT REMOVE & REPLACE			1996	2,686	69	39	69		297	20
21	ROOF REPAIR			1996	7,000	179	39	179		768	21
22	HOT WATER TANK			1996	12,098	310	39	310		1,279	22
23	CABINETS, SINK, COUNTERTOP, SHELVES			1997	6,844	175	39	175		576	23
24	REHAB ROOM, FLOORING,HAND RAILS			1997	105,092	2,695	39	2,695		8,941	24
25	ROOFING			1997	45,500	1,167	39	1,167		3,842	25
26	FLOOR TILES, DOORS, WINDOW TREATMENTS			1997	4,721	121	39	121		398	26
27	FIRE ALARM, AIR UNIT, LAUNDRY REPAIRS			1997	26,497	679	39	679		2,235	27
28	FIRE ALARM REPAIR, DOOR ALARM			1998	3,359	86	39	86		209	28
29	DRAPES & INSTALLATION			1998	5,965	153	39	153		361	29
30	FLOOR TILE, HAND RAILS, DOOR MAGNETS, ROOM SIGI			1998	14,240	365	39	365		864	30
31	EXHAUST FAN & INSTALLATION			1998	2,285	59	39	59		130	31
32	ROOF REPAIR			1998	8,750	224	39	224		534	32
33	DRYWALL,PLASTER,PAINT,WALLPAPER HALLWAYS			1998	22,500	577	39	577		1,386	33
34	ELECTRICAL WORK			1998	5,376	138	39	138		325	34
35	COUNTER TOPS			1998	712	18	39	18		42	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 203,896		$ 118,953	$ (84,943)	$ 1,549,474	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	PARKING LOT IMPROVEMENT			1999	1,185	30	39	30		60	9
10	NURSES STATION			1999	16,601	426	39	426		835	10
11	ALUMINUM WINDOWS			1999	4,740	122	39	122		137	11
12	FIRE SYSTEM			1999	2,625	67	39	67		130	12
13	FLOOR TILE			1999	10,807	277	39	277		543	13
14	DOOR AND MAGNET			1999	9,601	246	39	246		424	14
15	ELECTRICAL WORK IN KITCHEN			1999	8,850	227	39	227		338	15
16	AIR CONDITIONING			1999	14,451	371	39	371		629	16
17	RAILINGS			1999	3,282	84	39	84		137	17
18	ROOF WORK			1999	4,500	115	39	115		149	18
19	NURSE STATION			2000	7,090	141	27.5	141		141	19
20	ALARM REPAIR/CAMERA/ANNUNCIATOR			2000	6,344	130	27.5	130		130	20
21	ROOF REPAIR			2000	8,378	173	27.5	173		173	21
22	PAVEMENT PATCH			2000	2,580	51	27.5	51		51	22
23	SMOKE DETECTOR			2000	3,472	68	27.5	68		68	23
24											24
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 2,528		$ 2,528	$	$ 3,945	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
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36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
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	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6
37	Purchased in Prior Years	$ 353,298	$ 51,267	$ 32,511	$ (18,756)	10-15 YRS	$ 139,275
38	Current Year Purchases	47,644	6,808	2,382	(4,426)	10-15 YRS	2,382
39	Fully Depreciated Assets	111,933					111,933
40	RELATED PARTY	18,495	1,965	1,754	(211)		8,266
41	TOTALS	$ 531,370	$ 60,040	$ 36,647	$ (23,393)		$ 261,856

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
42	RELATED PARTY			$ 1,131	$ 218	$ 188	$ (30)		$ 188
43									
44									
45									
46	TOTALS			$ 1,131	$ 218	$ 188	$ (30)		$ 188

E. Summary of Care-Related Assets

		1 Reference	2 Amount
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 266,682
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 158,316
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (108,366)
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,815,463

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost
58		$
59		
60		
61		$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending:

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____ This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agr
Beginning ____
Ending ____

11. Rent to be paid in future years unde rental agreement:

	Fiscal Year Ending	Annual R
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipme $ 4,620 Description: SEE SCHEDULE ATTACHED (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the buil please provide complete details on a schedule.

** This amount plus any amortization expense must agree with page 4, lin

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STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending:

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount o
facility received training aides from o

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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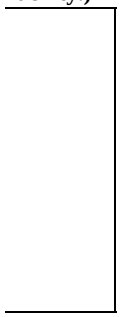
facility.)



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ther facilities.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)
1	Licensed Occupational Therapist	39-3	hrs	$		$ 15,346	$		$ 15,346
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,807			7,807
3	Licensed Recreational Therapist		hrs						
4	Licensed Physical Therapist	39-3	hrs			18,604			18,604
5	Physician Care	39-3	visits						
6	Dental Care		visits						
7	Work Related Program		hrs						
8	Habilitation		hrs						
9	Pharmacy	39-2	# of prescrpts				27,061		27,061
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs						
11	Academic Education		hrs						
12	Exceptional Care Program								
13	Other (specify):	39 - 2 & 3				5,094	9,874		14,968
14	TOTAL			$		$ 46,851	$ 36,935		$ 83,786

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 137,982	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	774,661		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,993		6
7	Other Prepaid Expenses	3,250		7
8	Accounts Receivable (owners or related parties)	48,256		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,002,142	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	529,379		15
16	Equipment, at Historical Cost	536,378		16
17	Accumulated Depreciation (book methods)	(445,255)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 620,502	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,622,644	$	25

		1 Operating	2 After Consolidation*
	C. Current Liabilities		
26	Accounts Payable	$ 218,445	$
27	Officer's Accounts Payable		
28	Accounts Payable-Patient Deposits		
29	Short-Term Notes Payable	127,549	
30	Accrued Salaries Payable	220,299	
31	Accrued Taxes Payable (excluding real estate taxes)	16,391	
32	Accrued Real Estate Taxes(Sch.IX-B)	242,000	
33	Accrued Interest Payable		
34	Deferred Compensation		
35	Federal and State Income Taxes		
	Other Current Liabilities(specify):		
36			
37			
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 824,684	$
	D. Long-Term Liabilities		
39	Long-Term Notes Payable		
40	Mortgage Payable		
41	Bonds Payable		
42	Deferred Compensation		
	Other Long-Term Liabilities(specify):		
43			
44			
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 824,684	$
47	**TOTAL EQUITY(page 18, line 24)**	$ 797,960	$
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,622,644	$

***(See instructions.)**

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Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 850,530	1
2	Restatements (describe):		2
3	IL REPLACEMENT TAX	(10,491)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 840,039	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	347,921	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(390,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (42,079)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 797,960	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,167,522	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,167,522	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,681	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 63,681	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,132	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 2,132	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	760	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 760	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29**	$ 5,234,095	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 837,464	31
32	Health Care	1,888,891	32
33	General Administration	1,091,875	33
	B. Capital Expense		
34	Ownership	901,808	34
	C. Ancillary Expense		
35	Special Cost Centers	83,786	35
36	Provider Participation Fee	82,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,886,174	40
41	**Income before Income Taxes (line 30 minus line 40)****	347,921	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 347,921	43

*** This must agree with page 4, line 45, column 4.**

**** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning 01/01/2000 Ending:

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,038	2,312	$ 64,486	$ 27.89	1
2	Assistant Director of Nursing	1,240	1,264	26,897	21.28	2
3	Registered Nurses	8,281	8,433	153,297	18.18	3
4	Licensed Practical Nurses	35,427	37,386	600,811	16.07	4
5	Nurse Aides & Orderlies	80,822	84,747	744,154	8.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	198	120	1,255	10.46	9
10	Activity Assistants	12,619	13,673	99,544	7.28	10
11	Social Service Workers	1,935	2,109	25,220	11.96	11
12	Dietician	1,958	2,171	28,202	12.99	12
13	Food Service Supervisor					13
14	Head Cook	4,828	5,133	42,991	8.38	14
15	Cook Helpers/Assistants	13,550	14,687	98,720	6.72	15
16	Dishwashers					16
17	Maintenance Workers	4,181	4,477	54,414	12.15	17
18	Housekeepers	2,690	2,862	17,789	6.22	18
19	Laundry					19
20	Administrator	1,958	2,241	58,874	26.27	20
21	Assistant Administrator	2,209	2,484	39,527	15.91	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,038	7,641	99,232	12.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,850	1,922	15,551	8.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,822	193,662	$ 2,170,964 *	$ 11.21	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period
35	Dietary Consultant	239	$ 5,772
36	Medical Director	MONTHLY	600
37	Medical Records Consultant		0
38	Nurse Consultant		0
39	Pharmacist Consultant	96	1,980
40	Physical Therapy Consultant	322	11,261
41	Occupational Therapy Consulta	58	2,013
42	Respiratory Therapy Consultant		0
43	Speech Therapy Consultant	101	3,526
44	Activity Consultant	47	2,217
45	Social Service Consultant	78	4,212
46	Other(specify)		
47			0
48			
49	TOTAL (lines 35 - 48)	941	$ 31,581

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages
50	Registered Nurses		$
51	Licensed Practical Nurses		
52	Nurse Aides	3,972	68,424
53	TOTAL (lines 50 - 52)	3,972	$ 68,424

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Schedule V Line & Column Reference	
1-3	35
9-3	36
10-3	37
10-3	38
10-3	39
10a-3	40
10a-3	41
10a-3	42
10a-3	43
11-3	44
12-3	45
	46
	47
	48
	49

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Schedule V Line & Column Reference	
10-3	50
10-3	51
10-3	52
	53

STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending: 1

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANN MARIE HARRINGTON	ADMIN		$ 58,874
JOYCE MCGEE	ASST ADMIN		39,527
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 98,401

B. Administrative - Other

Description	Amount
DYNAMIC HEALTH CARE CONSULTANTS	$ 100,800
FRED AARON	19,200
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 120,000

C. Professional Services

Vendor/Payee	Type	Amount
HDSI	DATA PROCESSING	$ 2,760
KRUPNICK, BOKOR	ACCOUNTING	10,234
FROST, RUTTENBERG	ACCOUNTING	6,685
SACHNOFF, WEAVER	LEGAL	3,756
BURKE, WARREN, MACKAY	LEGAL	218
FINKEL MARTWICK	LEGAL	3,089
ISP	BACKGROUND CHECK	364
PERSONNEL PLANNERS	UC CONSULTANT	950
ECONOCARE	PURCHASING CONSULT/	2,700
JOHN J CLARKE	BACKGROUND CHECK	10
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 30,766

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,181
Unemployment Compensation Insurance	25,585
FICA Taxes	165,306
Employee Health Insurance	115,515
Employee Meals	27,413
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	0
EMPLOYEE BENEFITS-OTHER	14,840
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 393,840

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promo

Description	
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Chec	
(Indicate # of checks performed)	
ADV & PROMO/MARKETING	
DUES & SUBSCRIPTIONS	
LICENSES & PERMITS	
TRUST FEES, CONTRIBUTIONS,etc.	
MGMT CO ALLOCATION	
LESS TRUST FEES, CONTRIB, etc.	
Less: Public Relations Expense	(
Non-allowable advertising	
Yellow page advertising	(
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	
Out-of-State Travel	$
In-State Travel	
EDUCATION & SEMINAR	
RELATED PARTY	
Seminar Expense	
Entertainment Expense	(
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

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tions Amount
19,648
0
35,385
5,696
858
3,325
804
(3,325)
)
(35,385)
0)
27,006

Amount
4,085
579
)
4,664

STATE OF ILLINOIS

Facility Name & ID Numb WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2000 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12
		Month & Year			Amount of Expense Amortized Per Year							
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004
1	PAINT/DECORATI	1997	$ 52,354	3	$ 8,726	$ 17,451	$ 17,451	$ 8,726	$	$	$	$
2	PAINT/DECORATI	1998	25,727	3		4,288	8,576	8,576	4,287			
3	PAINT/DECORATI	1999	3,946	3			658	1,315	1,315	658		
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16												
17												
18												
19												
20	TOTALS		$ 82,027		$ 8,726	$ 21,739	$ 26,685	$ 18,617	$ 5,602	$ 658	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost repo **YES**
If YES, give association name and amou **IL COUNCIL LONG TERM CARE $3,206**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at th end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this peri **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. **465** Line **10**

(7) Have all costs reported on this form been determined using accounting procedure consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangemen **NO**
If YES, give effective date of lease

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII) YES NO **X** If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. **82,350**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed t the Department of Public Aid, in addition to the daily rate, been properly classif in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care servi the patient census listed on page 2, Sectic **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, a a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee bene on Schedule V. $ **0** Has any meal income been offset agai related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical trans residents? **NO** If YES, please indicate the amount of income earned fr program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patie
d. Have vehicle usage logs been maintain **NO**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjuste out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting **NO**
Firm Name: The instruction cost report require that a copy of this audit be included with the cost report. Has been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjust out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of s performed been attached to this cost repo **YES**
Attach invoices and a summary of services for all architect and appraisal fees

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Facility Name & ID Number WINDMILL NURSING PAVILION #0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL		LINE		SCHED REF	TOTAL	
1	DIETARY				10	NURSING			
	DIETITIAN CONSULTANT	XVIII B35	5772			CONTRACT NURSING	XVIII C53	68424	
	REPAIRS & MAINTENANCE		597			LABORATORY & XRAY EXPENSE		0	
			0	6369		PURCHASED SERVICES		0	
3	HOUSEKEEPING					PSYCHO-SOCIAL CONSULTANT	XVIII B47	0	
			0			RESTORATIVE NURSING CONSULTA	XVIII B38	0	
			0	0		MEDICAL RECORDS CONSULTANT	XVIII B37	0	
4	LAUNDRY					PHARMACY CONSULTANT	XVIII B39	1980	
	EQUIPMENT REPAIRS & MAINTENANCE		4684			UTILIZATION REVIEW FEES	XVIII B	0	
	CONTRACTED LAUNDRY SERV		70200	74884		PHYSICIANS	XVIII B	0	
5	HEAT & OTHER UTILITIES					PSYCHIATRIC	XVIII B	0	
	GAS HEAT		27963			RN CONSULTANT	XVIII B38	0	
	ELECTRICITY		51820					0	
	WATER		15018					0	70404
	CABLE TV - LOBBY		0		10a	THERAPY			
			0	94801		PHYSICAL THERAPY SERVICES		0	
6	MAINTENANCE					SPEECH THERAPY SERVICES			
	GROUNDS MAINTENANCE		5671			OCCUPATIONAL THERAPY SERVICES		0	
	PAINTING & DECORATING		2542			REHABILITATION CONSULTANT	XVIII B	0	
	BUILDING REPAIRS		0			PHYSICAL THERAPY CONSULTANT	XVIII B40	11261	
	MAINTENANCE TRAVEL		0			OCCUPATIONAL THERAPY CONSUL	XVIII B41	2013	
	EQUIPMENT MAINTENANCE & REPAIR		3400			SPEECH THERAPY CONSULTANT	XVIII B43	3526	
	ELEVATOR MAINTENANCE & REPAIR		0			RESPIRATORY CONSULTANT	XVIII B42	0	16800
	OUTSIDE LABOR		0		11	ACTIVITIES			
	EXTERMINATING SERVICE		4275			CABLE TV - PATIENT ROOMS		542	
	FIRE SERVICE		0			ACTIVITY REHAB CONSULTANT	XVIII B44	2217	
	CONTRACTED BLDG MAINTENANCE		127800					0	2759
			0		12	SOCIAL SERVICES			
			0	143688		SOCIAL REHABILITATION SERVICES		0	
7	OTHER					SOCIAL REHABILITATION CONSULT	XVIII B45	0	
	SCAVENGER		9860			SOCIAL WORKER	XVIII B45	4212	
	SECURITY SERVICE		0	9860				0	4212
9	MEDICAL DIRECTOR				13	NURSE AIDE TRAINING			
	MEDICAL DIRECTOR FEES	XVIII B36	600	600		NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WINDMILL NURSING PAVILION #0031823 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION		0	0
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B	120000	120000
18	DIRECTORS FEES		0	0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	2760	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	28006	
	ACCOUNT COLLECTION FEES		0	30766
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT	VI 19 XIX F	0	
	ADV & PROMO/MARKETING	VI 25 XIX F	35385	
	EMPLOYEE WANT ADS	XIX F	19648	
	CONTRIBUTIONS	VI 20 XIX F	100	
	DUES & SUBSCRIPTIONS	XIX F	5696	
	LICENSES & PERMITS	XIX F	858	
	PUBLIC RELATIONS-PATIENT RELA	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES/FRANCHISE TAX	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3225	
	H/CARE WORKER BACKGROUND CH	XIX F	0	64912
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES		91	
	EQUIPMENT REPAIR & MAINTENANCE		8244	
	OUTSIDE CLERICAL SERVICES		182900	
	PENALTIES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15467	
	MESSENGER SERVICE		0	
			0	206702

LINE		SCHED REF		TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES	XIX D	165306	
	UNEMPLOYMENT COMPENSATION	XIX D	25585	
	WORKERS COMPENSATION INSURA	XIX D	45181	
	HOSPITALIZATION INSURANCE	XIX D	115515	
	EMPLOYEE BENEFITS - OTHER	XIX D	14840	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING CONTRII	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	366427
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		0	0
24	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS	XIX G	4085	
	TRAVEL	XIX G	0	
			0	
				4085
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		1545	1545
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		84823	84823
27	OTHER			
	BAD DEBTS	VI 24	0	
			0	0
	GRAND TOTAL COLUMN 3 OTHER			1303637